FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030015

Facility Name: WESTMONT CONVALESCENT CENTER

Address: 6501 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 960-2026 **Fax #** (630) 960-0480

IDPA ID Number: 36-3376606

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) FLORA WEISS
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,401	6,165	8,974	24,540	8
9	SNF/PED					9
10	ICF	38,339	9,706	49	48,094	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,740	15,871	9,023	72,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

D. How many bed-hold days during this year were paid by Public Aid?
37 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 7,552

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,860	25,803	9,367	326,030		326,030		326,030			1
2	Food Purchase		254,275		254,275		254,275	(1,052)	253,223			2
3	Housekeeping	234,732	46,404		281,136		281,136		281,136			3
4	Laundry	163,244	22,816	3,321	189,381		189,381		189,381			4
5	Heat and Other Utilities			213,643	213,643		213,643		213,643			5
6	Maintenance	80,450	38,542	27,292	146,284		146,284	(452)	145,832			6
7	Other (specify):*			20,271	20,271		20,271		20,271			7
8	TOTAL General Services	769,286	387,840	273,894	1,431,020		1,431,020	(1,504)	1,429,516			8
	B. Health Care and Programs											
9	Medical Director			49,500	49,500		49,500		49,500			9
10	Nursing and Medical Records	2,675,446	152,981	59,268	2,887,695		2,887,695		2,887,695			10
10a	Therapy	111,079	2,727	1,701	115,507		115,507		115,507			10a
11	Activities	161,682	582		162,264		162,264		162,264			11
12	Social Services	86,088		871	86,959		86,959		86,959			12
13	Nurse Aide Training			2,487	2,487		2,487		2,487			13
14	Program Transportation			414	414		414		414			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,034,295	156,290	114,241	3,304,826		3,304,826		3,304,826			16
	C. General Administration											
17	Administrative	211,061		1,024,700	1,235,761		1,235,761		1,235,761			17
18	Directors Fees											18
19	Professional Services			43,763	43,763		43,763		43,763			19
20	Dues, Fees, Subscriptions & Promotions			28,749	28,749		28,749	(12,596)	16,153			20
21	Clerical & General Office Expenses	183,631	26,875	41,438	251,944		251,944	(15,275)	236,669			21
22	Employee Benefits & Payroll Taxes			728,592	728,592		728,592		728,592			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,863	2,863		2,863		2,863			24
25	Other Admin. Staff Transportation			718	718		718		718			25
26	Insurance-Prop.Liab.Malpractice			208,761	208,761		208,761		208,761			26
27	Other (specify):*			58,732	58,732		58,732	(58,732)				27
28	TOTAL General Administration	394,692	26,875	2,138,316	2,559,883		2,559,883	(86,603)	2,473,280			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,198,273	571,005	2,526,451	7,295,729		7,295,729	(88,107)	7,207,622			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: WESTMONT CONVALESCENT CENTER #0030015 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,650	
	REPAIRS & MAINTENANCE		4,717	
			0	9,367
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,321	
			0	3,321
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		50,438	
	ELECTRICITY		84,690	
	WATER		78,515	
	CABLE TV - LOBBY		0	
			0	213,643
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,267	
	PAINTING & DECORATING		2,834	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,105	
	ELEVATOR MAINTENANCE & REPAIR		4,240	
	OUTSIDE LABOR		4,800	
	EXTERMINATING SERVICE		4,889	
	FIRE SERVICE		2,157	
			0	
			0	
			0	27,292
7	**OTHER**			
	SCAVENGER		20,001	
	SECURITY SERVICE		270	20,271
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	49,500	49,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	41,029	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,265	
	PHARMACY CONSULTANT	XVIII B 39-2	13,129	
	UTILIZATION REVIEW FEES	XVIII B __-2	2,100	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,745	
			0	
			0	59,268
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,701	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,701
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	871	
			0	871
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	2,487	2,487

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		414	414
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,024,700	1,024,700
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,786	
	ADMINISTRATIVE CONSULTANTS	XIX C	5,000	
	PROFESSIONAL FEES	XIX C	21,977	
			0	43,763
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,919	
	EMPLOYEE WANT ADS	XIX F	7,543	
	CONTRIBUTIONS	VI 20 XIX F	200	
	DUES & SUBSCRIPTIONS	XIX F	6,600	
	LICENSES & PERMITS	XIX F	2,010	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,327	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	28,749
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		377	
	EQUIPMENT REPAIR & MAINTENANCE		3,754	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	15,275	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,032	
	MESSENGER SERVICE		0	
			0	41,438

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	313,244	
	UNEMPLOYMENT COMPENSATION	XIX D	56,899	
	WORKERS COMPENSATION INSURANCI	XIX D	128,899	
	HOSPITALIZATION INSURANCE	XIX D	118,910	
	EMPLOYEE BENEFITS - OTHER	XIX D	107,570	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,070	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	728,592
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS			0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,863	
	TRAVEL	XIX G	0	
			0	
			0	2,863
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		718	718
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		208,761	208,761
27	**OTHER**			
	BAD DEBTS	VI 24	58,732	
				58,732

GRAND TOTAL COLUMN 3 OTHER 2,526,451

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			308,888	308,888		308,888	102,418	411,306			30
31	Amortization of Pre-Op. & Org.			21,201	21,201		21,201		21,201			31
32	Interest			648,635	648,635		648,635		648,635			32
33	Real Estate Taxes			87,120	87,120		87,120		87,120			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			83,939	83,939		83,939		83,939			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,149,783	1,149,783		1,149,783	102,418	1,252,201			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		240,679	354,563	595,242		595,242		595,242			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,036	118,036		118,036		118,036			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		240,679	472,599	713,278		713,278		713,278			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,198,273	811,684	4,148,833	9,158,790		9,158,790	14,311	9,173,101			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	102,418	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,052)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(15,275)	21		18
19	Entertainment		20		19
20	Contributions	(3,527)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(58,732)	27		24
25	Fund Raising, Advertising and Promotional	(8,919)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(452)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 14,311		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 14,311		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
WESTMONT CONVALESCENT CENTER
ID# 0030015
Report Period Beginning: 01/01/2004
Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -452	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(452)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,052)	0	0	0	0	0	0	0	0	0	0	(1,052)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(452)	0	0	0	0	0	0	0	0	0	0	(452)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,504)	0	0	0	0	0	0	0	0	0	0	(1,504)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(12,596)	0	0	0	0	0	0	0	0	0	0	(12,596)	20
21	Clerical & General Office Expenses	(15,275)	0	0	0	0	0	0	0	0	0	0	(15,275)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(58,732)	0	0	0	0	0	0	0	0	0	0	(58,732)	27
28	**TOTAL General Administration**	(86,603)	0	0	0	0	0	0	0	0	0	0	(86,603)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(88,107)	0	0	0	0	0	0	0	0	0	0	(88,107)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	102,418	0	0	0	0	0	0	0	0	0	0	102,418	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	102,418	0	0	0	0	0	0	0	0	0	0	102,418	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	14,311	0	0	0	0	0	0	0	0	0	0	14,311	45

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.22				MGMT. FEE	$ 512,350	17-3	1
2	DANIEL WEISS	ADMINISTRATOR	ADMINISTRAT.	0.00	SEE ATTACHED			SALARY	147,078	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.16				MGMT. FEE	512,350	17-3	3
4	RICHARD HOLT	GEN. PARTNER	SECURITY	0.00				OUTS. LAB	4,800	6-3	4
5	NANCY GERACI	ADMINISTRATOR	ADMINISTRAT.	0.09				SALARY	4,623	17-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.09				SALARY	45,490	21-1	6
7	JANE HOLT	MDS. COMP. INPUT	COMP. INPUT	0.00				SALARY	12,000	10-1	7
8	VASCO HOLD	CLERK	IN SERV TRAIN	0.00				SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0.00	SEE ATTACHED			SALARY	16,800	21-1	9
10	CAROLYN HOLT	CLERK	CLERICAL	0.00				SALARY	9,600	21-1	10
11											11
12											12
13								TOTAL	$ 1,290,291		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	KEY COMMERCIAL		X	MORTGAGE	$86,077.00	05/01/98	$ 10,000,000	$ 8,807,802	05/01/23	7.2800	$ 648,635	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$86,077.00		$ 10,000,000	$ 8,807,802			$ 648,635	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 8,807,802			$ 648,635	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 83,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 84,637	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,637	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 85,483	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 87,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	72,603	8
	2000	75,156	9
	2001	81,217	10
	2002	82,311	11
	2003	84,637	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT CONVALESCENT CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0030015

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 80,638.20	$ 80,638.20
2.	09-22-101-002	NURSING HOME	$ 3,998.88	$ 3,998.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 84,637.08	$ 84,637.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1995	$ 349,103	1
2					2
3	TOTALS			$ 349,103	3

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		$ 4,982,301	$ 127,751	39	$ 127,751	$	$ 1,251,019	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641	2,165	19	2,165		38,778	9
10	ROOF & WATER LINE			1987	31,143	989	20	1,557	568	27,240	10
11	IMPROVEMENTS			1988	44,614	1,416	31.5	1,416		23,359	11
12	IMPROVEMENTS			1989	40,935	1,299	31.5	1,299		20,076	12
13	DRIVEWAY			1989	17,137	1,142	15	1,142		14,606	13
14	IMPROVEMENTS			1990	37,367	1,186	31.5	1,186		17,146	14
15	IMPROVEMENTS			1991	45,002	1,428	31.5	1,428		19,039	15
16	IMPROVEMENTS			1992	49,649	1,577	31.5	1,577		19,619	16
17	ROOF TOP A/C UNITS			1993	9,100	289	31.5	289		3,444	17
18	IMPROVEMENTS			1993	53,243	1,366	39	1,366		15,559	18
19	IMPROVEMENTS			1994	31,230	801	39	801		8,527	19
20	FLOOR COVERING			1995	795	20	15	53	33	530	20
21	HAND RAIL			1995	2,249	58	39	58		573	21
22	FLOOR TILES			1995	5,471	140	39	140		1,348	22
23	WINDOW A/C UNITS			1995	14,146	363	39	363		3,432	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056	309	39	309		2,949	24
25	ALARM			1995	1,337	34	39	34		322	25
26	LAUNDRY BUILDING			1995	35,000	897	39	897		8,335	26
27	ROOF			1995	5,520	142	39	142		1,319	27
28	WINDOWS			1995	9,478	243	39	243		2,238	28
29	DOOR EDGE & DOOR FRAME			1996	2,099	54	39	54		484	29
30	LAUNDRY BUILDING			1996	175,187	4,491	39	4,491		38,371	30
31	AIR COOLERS			1996	6,642	171	39	171		1,451	31
32	RACING CAGE			1996	3,987	102	39	102		871	32
33	HAND RAIL			1996	1,156	30	39	30		251	33
34	WINDOWS			1996	11,496	295	39	295		2,471	34
35	TACK ROOM			1996	2,139	55	39	55		456	35
36	NEW CONFERENCE ROOM-TILE			1997	2,938	76	39	76		554	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	$ 1,478	$ 38	39	$ 38	$	$ 277	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		984	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		249	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		223	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1997	4,927	126	39	126		846	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		17,748	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		1,103	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		1,997	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		1,603	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		508	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		217	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		416	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		1,275	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		333	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		370	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		384	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		405	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		159	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		948	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		353	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	328	20	163	(165)	815	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		558	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		4,200	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		644	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		428	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		691	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	8,108	20	4,026	(4,082)	20,130	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		4,217	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		13,173	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		1,007	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		1,378	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861	35,067	20	13,543	(21,524)	54,172	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	4,716	20	1,456	(3,260)	4,368	69
70	TOTAL (lines 4 thru 69)		$ 6,386,654	$ 209,578		$ 181,148	$ (28,430)	$ 1,660,546	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,386,654	$ 209,578		$ 181,148	$ (28,430)	$ 1,660,546	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	630	15	600	(30)	1,380	2
3	SHOWER ROOM	2002	30,924	1,125	27.5	1,125		2,484	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	328	27.5	328		670	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	541	27.5	541		1,105	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	8,316	20	2,003	(6,313)	6,009	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	2,387	20	575	(1,812)	1,725	7
8	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2003	12,767	464	27.5	464		677	8
9	2ND FL NURSING STATION, CORRIDOR, RESIDENT ROOM	2003	31,152	1,133	27.5	1,133		1,652	9
10	THERAPY ROOM -FLOORING	2003	87,509	3,182	27.5	3,182		4,640	10
11	CONFERENCE ROOM-FLOORING	2003	2,073	76	27.5	76		111	11
12	LARGE DINING ROOM-BUILT IN TV CABINET	2004	7,421	124	27.5	124		124	12
13	TONE/VISUAL/VOICE NURSE CALL SYSTEM	2004	89,825	953	27.5	953		953	13
14	REMODEL OF RESIDENT ROOMS AND BATHROOMS	2004	50,925	386	27.5	386		386	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,783,703	$ 229,223		$ 192,638	$ (36,585)	$ 1,682,462	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,070,518	$ 43,356	$ 215,131	$ 171,775	3-10	$ 2,025,513	71
72	Current Year Purchases	60,513	36,309	3,537	(32,772)	8-10	3,537	72
73	Fully Depreciated Assets	234,251						73
74								74
75	TOTALS	$ 2,365,282	$ 79,665	$ 218,668	$ 139,003		$ 2,029,050	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	9,498,088	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	308,888	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	411,306	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	102,418	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,711,512	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 47,696 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2001 BMW	$ #######	$ 13,500	17
18	ADMINISTRATIVE	2004 LEXUS	#######	12,362	18
19	HSKP, MAINT	2004 FORD PASS VAN	775.00	10,381	19
20					20
21	TOTAL		$ #######	$ 36,243	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 130

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE [ ]

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,037		1,037
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,450		1,450
9	TOTALS	$	$ 2,487	$	$ 2,487
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,487			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 164,001	$		$ 164,001	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,068			29,068	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			161,494			161,494	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				205,401		205,401	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB,TUBE FEEDING,RADIOLOGY Other (specify): MEDICAL SUPPLIES	39-2 39-2					31,968 3,310		31,968 3,310	13
14	TOTAL			$		$ 354,563	$ 240,679		$ 595,242	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,249,924	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,268,918		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	254,835		6
7	Other Prepaid Expenses	24,642		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate & Ins Escrow	84,618		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,882,937	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	1,801,402		15
16	Equipment, at Historical Cost	2,365,282		16
17	Accumulated Depreciation (book methods)	(4,219,165)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): AMOTR OF DEF MTG COST	(141,242)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,392,094	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,275,031	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 195,901	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,091		30
31	Accrued Taxes Payable (excluding real estate taxes)	61,480		31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,483		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 485,955	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	8,807,802		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,807,802	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,293,757	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,018,726)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,275,031	$	48

*(See instructions.)

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,105,126)	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,105,124)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,161,398	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,075,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 86,398	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,018,726)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,026,170	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,026,170	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,498	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,498	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,928	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,928	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,354	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,354	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	12,518	28
28a	VENDING COMMISSIONS	534	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,052	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,338,002	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,431,020	31
32	Health Care	3,304,826	32
33	General Administration	2,559,883	33
	B. Capital Expense		
34	Ownership	1,149,783	34
	C. Ancillary Expense		
35	Special Cost Centers	595,242	35
36	Provider Participation Fee	118,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,158,790	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,179,212	41
42	**Income Taxes**	(17,814)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,161,398	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,997	2,077	$ 75,724	$ 36.46	1
2	Assistant Director of Nursing	2,023	2,104	59,646	28.35	2
3	Registered Nurses	42,771	45,514	1,101,486	24.20	3
4	Licensed Practical Nurses	9,453	10,606	224,280	21.15	4
5	Nurse Aides & Orderlies	100,785	103,721	1,007,691	9.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	24	24	475	19.79	7
8	Rehab/Therapy Aides	7,146	7,650	110,604	14.46	8
9	Activity Director	4,264	4,621	64,595	13.98	9
10	Activity Assistants	10,804	11,310	97,087	8.58	10
11	Social Service Workers	5,393	5,808	86,088	14.82	11
12	Dietician					12
13	Food Service Supervisor	2,033	2,383	46,699	19.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,483	28,167	244,161	8.67	15
16	Dishwashers					16
17	Maintenance Workers	5,924	6,304	80,450	12.76	17
18	Housekeepers	32,365	33,269	234,732	7.06	18
19	Laundry	22,182	23,237	163,244	7.03	19
20	Administrator	2,474	2,543	143,820	56.56	20
21	Assistant Administrator	2,165	2,245	67,241	29.95	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,406	22,117	183,631	8.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	16,541	18,483	206,619	11.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	316,233	332,183	$ 4,198,273 *	$ 12.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	93	$ 4,650	1-3	35
36	Medical Director	Monthly Fee	49,500	9-3	36
37	Medical Records Consultant	23	1,265	10-3	37
38	Nurse Consultant	Monthly Fee	1,745	10-3	38
39	Pharmacist Consultant	Monthly Fee	13,129	10-3	39
40	Physical Therapy Consultant	34	1,701	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	17	871	12-3	45
46	Other(specify)				46
47	Utilization Review Fees	Monthly Fee	2,100	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	167	$ 74,961		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	513	$ 15,206	10-3	50
51	Licensed Practical Nurses	39	1,178	10-3	51
52	Nurse Aides	2,465	24,645	10-3	52
53	TOTAL (lines 50 - 52)	3,017	$ 41,029		53

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY GERACI	ADMIN	.0093	$ 4,623
DANIEL WEISS	ADMIN	0	139,197
BARBARA WULF	ASST ADMIN	0	59,360
DANIEL WEISS	ASST ADMIN	0	7,881
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 211,061

B. Administrative - Other

Description		Amount
WESTMONT G.P.	MANAGEMENT FEES	$ 1,024,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 1,024,700

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		43,763
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 43,763

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 128,899
Unemployment Compensation Insurance		56,899
FICA Taxes		313,244
Employee Health Insurance		118,910
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		107,570
EMPLOYEE PHYSICAL EXAMS		3,070
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,543
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,919
TRUST/FRANCHISE/CONTRIB/ETC	3,677
LICENSES & PERMITS	2,010
DUES & SUBSCRIPTIONS	6,600
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(3,677)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,919)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,153

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	2,863
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,863

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	7/01	$ 2,495	3YR	$ 416	$ 832	$ 832	$ 415	$	$	$	$	$
2	PAINTING/DECORATIN	7/02	2,297	3YR		383	766	766	382				
3	PAINTING/DECORATIN	7/03	2,188	3YR			365	729	729	365			
4	PAINTING/DECORATIN	7/04	2,834	3YR				472	945	945	472		
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,814		$ 416	$ 1,215	$ 1,963	$ 2,382	$ 2,056	$ 1,310	$ 472	$	$

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 6600**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,207** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **118,036**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees